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IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF NORTH CAROLINA  
WESTERN DIVISION  
NO. 5:19-CV-512-BO

UNITED STATE OF AMERICA , ex rel.,  
ANJELICA BROWN,  
  
Plaintiff,

vs .

MINDPATH CARE CENTERS, NORTH  
CAROLINA, PLLC; JEFF WILLIAMS;  
ABIGAIL SHERIFF, and SARAH  
WILLIAMS,

Defendants.

\* \* \*CONFIDENTIAL\* \* \*

VIDEOTAPED DEPOSITION OF GEORGE CORVIN, M.D.  
(Taken by Defendant)  
Raleigh, North Carolina  
Tuesday, March 11, 2025

Reported in Stenotype by  
Jana F. Collins

Transcript produced by computer-aided transcription

**GOVERNMENT  
EXHIBIT  
B**

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ALSO PRESENT: MATT WALTERS, Videographer

VIDEOTAPED DEPOSITION OF GEORGE CORVIN,  
M.D., a witness called on behalf of Defendants,  
before Jana Collins, Notary Public, in and for the  
State of North Carolina, at the United States  
Attorney's Office, 150 Fayetteville Street, Raleigh,  
North Carolina, on Tuesday, the 11th day of March,  
2025, commencing at 9:25 a.m.

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1 A I'll try to do that.

2 Q Okay. And the court reporter and I will  
3 help you remember if that happens.

4 A Yes, ma'am.

5 Q Let me know if you want to take a break  
6 today at any point.

7 A Will do.

8 Q If I'm in the middle of a line of  
9 questioning, I might ask to finish that line before  
10 we start, but we want you to be comfortable today.

11 A Thank you.

12 Q Are you represented by an attorney today?

13 A No, ma'am.

14 Q Okay, all right. Is there any reason you  
15 can't answer truthfully and honestly today?

16 A No, ma'am.

17 Q Are you taking any sort of medication that  
18 will affect your memory or ability to understand my  
19 questions?

20 A No, ma'am.

21 Q Do you have any medical condition that would  
22 affect your ability to understand the questions?

23 A No, ma'am.

24 Q Do you have any medical condition that would  
25 affect your ability to recall details or events?

1 Q Okay. Did you --

2 A I should say I talk to her about every case  
3 I take, so.

4 Q Okay. Did you speak to anyone else?

5 A I don't think so. No, ma'am.

6 Q Okay. The government has produced your  
7 report, CV, and different documentation. We're  
8 going to hand you what will be Exhibit Number 306?

9 THE COURT REPORTER: 325.

10 MS. HARRIS: 325.

11 (EXHIBIT 325 WAS MARKED FOR  
12 IDENTIFICATION)

13 MS. HARRIS: Here you go, Neal.

14 MR. FOWLER: Thank you, Alice.

15 BY MS. HARRIS:

16 Q You're welcome.

17 Dr. Corvin, I see you're looking at the  
18 documents. Can you confirm that that is your report  
19 and your findings?

20 A This is -- yeah. It's several documents in  
21 here, but the first part is a 9-page report and then  
22 a chart of summary and then my CV, my case list, a  
23 condition letter. And then, a document that I don't  
24 think I have -- I don't know that I've seen this  
25 actual last piece of this.

1 Q Okay. So now, that's very helpful. So what  
2 you're talking about then is -- if you look at the  
3 bottom of the pages, there's a Bates stamp.

4 A Yes, ma'am.

5 Q USA underscore 0004014.

6 A Correct.

7 Q Okay. So 4014 to 4016 are not your  
8 findings?

9 A Yeah. Well, I don't know what it is. I've  
10 never read it so, but it's not -- it doesn't look  
11 like something I prepared unless it got changed in  
12 format, but it doesn't look like something I've seen  
13 in this current form anyway.

14 Q Okay. So that's helpful. Up until that  
15 Bates stamp, up until 4000 to 4013 are documents  
16 that you prepared and provided in this case?

17 A That's correct.

18 Q Okay, thank you. That's helpful.

19 A Uh-huh.

20 Q Let's go to Bates -- the very first page at  
21 the bottom. This is the for the record, Bates  
22 stamped 4000. This is section Sources of  
23 Information.

24 A Yes.

25 Q Okay. And under that, you state at the top

1 you -- a sample of 60 progress notes?

2 A Yes, ma'am.

3 Q Okay. And did you review the medical  
4 documentation related to these 60 progress notes?

5 A That is correct. Sometimes it was  
6 duplicative but, yes. There was a way to look up  
7 the dates of service for each of these dates of  
8 service and then reviewed those notes.

9 Q Okay. And when you say there was a way to  
10 look up, are you looking at paper or electronic  
11 documents?

12 A It was all electronic.

13 Q Okay. And to your knowledge, were there  
14 Bates numbers at the bottom?

15 A I don't remember seeing Bates numbers on  
16 them. I'm not saying they're not there. I just --  
17 it never popped out to me if they were.

18 Q Okay. Do you know what database you were  
19 looking at?

20 A I don't really. I know that the folder  
21 names were like PROD 001, 011, and 013 primarily and  
22 then, there were image files within those.

23 Q Okay.

24 A I don't know if that helps any, but.

25 Q Okay. It does. Thank you. Did you look at

1 medical record documentation outside of the progress  
2 notes for these 60 patients?

3 A Not until yesterday. I did briefly  
4 yesterday --

5 Q Okay.

6 A -- in one patient.

7 Q And what patient was that?

8 A I don't remember. But if we go through  
9 these, I will tell you. And when we get to that, I  
10 can tell you why, so.

11 Q Okay. So what records or sources of  
12 information did you review or look at as you formed  
13 your opinions regarding these claims that you  
14 reviewed?

15 A So to a large extent, I mean above and  
16 beyond the medical record notes themselves, I'm not  
17 a coding expert. You probably already know that.  
18 So what I did is -- but as a physician that's been  
19 in practice for 30 years part of our training is, of  
20 course, in the utility of documentation. And so,  
21 for example, when I was still working in a hospital,  
22 I had folks that would be, I don't know, tasked with  
23 making sure that my documentation was adequate for  
24 the purposes that it's supposed to serve. And so, a  
25 lot of this is sort of my training and experience.

1 It's my training and experience having staff do  
2 internal audits on my own records. And also, from  
3 later in my career for me doing the same audits in a  
4 hospital setting and to a lesser extent in my  
5 outpatient practice setting.

6 And I think it might be on my resume or CV.  
7 I'm currently chairing the quality management  
8 function for the Medicaid MCO in Central Carolina.  
9 So a lot of what I'm using in terms of expertise, if  
10 you will, is simply just how I was taught, how I was  
11 trained, what I -- what I've always been told. This  
12 is what you need to do and it really kind of boils  
13 down to what standard of care is for me as a  
14 practicing physician in terms of documentation. But  
15 part of that is that I have folks that I've worked  
16 with over the years who have said, look. These are  
17 the things that have to be here. Attendings that  
18 taught me, folks that I worked with in medical  
19 records and peer review, things of that nature. So  
20 it's no short answer to that as you can probably  
21 tell, so.

22 Q So is the standard you're relying on  
23 published anywhere?

24 A If it is, it's not something I published.  
25 Now I am aware that there have over time been

1 multiple different sort of publications, if you  
2 will, federally in terms of documentation standards  
3 for Medicare provided services which is not  
4 something -- that's not something I live within,  
5 right.

6 Q Okay.

7 A In other words, I am aware of it and I kind  
8 of colloquially know it because I'm taught it and  
9 held to it because I write thousands of those notes.  
10 And so, but I'm not a coding expert. I can't quote  
11 statutes in that manner. I look at this more in  
12 terms of what is necessarily present in medical  
13 documentation to both comport with documentation  
14 guidelines federally, but more importantly as a  
15 physician whether they serve the purpose of  
16 providing the reviewer of those records necessary  
17 information about that patient's care. Does it  
18 document that that care is necessary and reasonable?  
19 Does it document what that care is? And so, it  
20 really becomes more of a standard of care clinical  
21 issue for me. But as you can imagine, there's  
22 tremendous overlap in those areas, right.

23 Q So this standard of care clinical issue,  
24 have you seen your version published anywhere?

25 A Not that I can quote to you now, although I

1 will tell you as a part of physician training like  
2 the actual organization of psychotherapy progress  
3 notes is something that all mental healthcare  
4 providers are trained in. And above and beyond any  
5 sort of statutory guidelines, there are guidelines  
6 that I can -- I can give you an example that are  
7 still critically needed to be present in those  
8 records because without them not only can you not  
9 document the necessary reasonableness of treatment,  
10 but it becomes difficult to understand even what the  
11 treatment is.

12 Q Okay. But if somebody were to say I want to  
13 look at Dr. Corvin's standard?

14 A Other than the way I've sort of summed it up  
15 in here, I don't know that I can give you a  
16 publication saying that.

17 Q So it's not published anywhere?

18 A No, no. Not that I'm -- well, I'm not  
19 saying it's not. It not that I can quote.

20 Q To your knowledge?

21 A Correct.

22 Q Okay. To your knowledge, it's not  
23 published?

24 A Correct.

25 Q So someone -- would you agree with me, and

1 we can look at it if we need to, the dates of  
2 service in these 60 are 2018, '19 and '20. Do you  
3 agree with that?

4 A I think that's right, yes.

5 Q So someone who's writing the notes in 2018,  
6 '19 and '20 would not have been aware of your  
7 standard?

8 MR. FOWLER: Objection to form.

9 A I suspect that they would actually.

10 Q Okay.

11 A Because it's -- because the standard -- it's  
12 my position, if I have a position, that the standard  
13 I'm utilizing is the same that every place I've ever  
14 worked held me to. It wasn't me doing it. It was  
15 how I was trained and it's how mental health  
16 professionals --

17 Q That's your personal experience, don't you  
18 agree?

19 MR. FOWLER: Objection to form.

20 A It -- well, it is my personal experience.  
21 But over the years, I've kind of gotten on the other  
22 side of that. And I know that that experience is in  
23 my experience, in my training has been relatively  
24 universal for mental healthcare providers.

25 Q When you're coding a claim in 2018, '19 or

1 '20, you agreed with me earlier you're not aware of  
2 any publication in which your standard is published?

3 A Well, I think the coding I mean to -- it's  
4 not a yes or no answer to that question. I will  
5 start by saying no, I'm not prepared to give you a  
6 document that says Dr. Corvin standard.

7 Q So you're not aware of Dr. Corvin's  
8 standards being --

9 A Being published.

10 Q Okay.

11 A That's not something I've ever done.

12 Q Okay.

13 A That being said, even if we look at  
14 applicable Medicare and Medicaid kind of guidelines  
15 on documentation, they do -- they are informed by  
16 the standard of care, but we haven't gotten to this  
17 yet. It's fairly obvious that the -- to define  
18 something as necessary and reasonable is very, very  
19 difficult to codify. And so, while there are  
20 efforts in mental health to do that -- well, for  
21 example, the coding expert report I read said that  
22 there is no universally government agreed upon  
23 diagnosis for psychotherapy. That's fine. That's  
24 what we do. We decide what that is because somebody  
25 must. And so, certain things are recognized as

1 psychotherapeutic modalities and other things are  
2 not, but it's very, very difficult to codify that.

3 Q So your standard of care then is fairly  
4 subjective, wouldn't you agree?

5 MR. FOWLER: Objection to form.

6 A I think I said that in my report.

7 Q Okay.

8 A There are -- there are aspects of an  
9 assessment of a mental health note that are by  
10 definition open to interpretation which is why I,  
11 and I think I said this in the report, really have  
12 tried to utilize a very permissive view of those  
13 issues. And let me just say I mean, I think the  
14 same is apparent in the coding report that I read  
15 which is there aren't definitions for these things.  
16 What I would say is that the absence of a definition  
17 of a code doesn't erase the necessity to meet that  
18 requirement from standard of care. That was a long  
19 sentence I know, but I'll try again later.

20 Q But again, I think what you're saying,  
21 correct me if I'm wrong, is that your view of the  
22 cases is like you said difficult to codify; is that  
23 correct?

24 MR. FOWLER: Objection to form.

25 A The provision of mental healthcare

1 completely is very difficult to codify. And, in  
2 fact, isn't codified completely.

3 Q Okay, all righty. So do you have --

4 A Of course -- I'm sorry. I didn't mean to --  
5 of course, that changes over time because of rules.

6 Q Of course, it does.

7 A Yeah, yeah.

8 Q So what was applicable in 2018, '19 and '20,  
9 for example, may be different in '21, '22, '23; is  
10 that correct?

11 A So -- so the coding, the language that's  
12 used has changed over time. The standard of care  
13 has not appreciable, in my opinion, not appreciably  
14 changed over time nor has the requirement that that  
15 documentation whatever you say has to be in there,  
16 it still has to be sufficiently detailed and unique  
17 applicable to that patient to demonstrate that that  
18 treatment is necessary and reasonable. That's  
19 overarching.

20 Q So who sets the standards for the detail  
21 that's required to be in the record?

22 A Who sets the standards? Well, in today, I'm  
23 offering my opinion as to what I think the standards  
24 are in 60 progress notes.

25 Q So that's your opinion then?

1 A These are my opinions.

2 Q Okay. And your opinions are what you think  
3 should be in the notes?

4 A That is correct. Based on my training and  
5 experience, having my own notes reviewed, and  
6 reviewing notes.

7 Q Okay, okay.

8 A Yeah.

9 Q Do you by chance know what the definition of  
10 a false claim is?

11 A I'm sure there's a technical definition that  
12 I don't know, but it seems like I might could get  
13 close to knowing it.

14 Q Do you know the definition of actual  
15 knowledge?

16 A Legally, no.

17 Q Okay.

18 A Or in coding language, I do not.

19 Q How about deliberate ignorance?

20 A That sounds like a -- if it's like  
21 deliberate indifference but not -- I can't quote you  
22 the definition.

23 Q And reckless disregard?

24 A Well, I know it in civil law, yes.

25 Q Okay, okay. All right. Let's look at your

1 have any N -- N -- the national documentation  
2 requirements?

3 A Correct.

4 Q Okay. All righty. Okay. Then let's hold  
5 this report here, but go back to your report.

6 A Uh-huh.

7 Q And on page 4 of your report and this is  
8 Bates-stamped 4003?

9 A Right.

10 Q You again state that the documentation must  
11 include issues that were addressed, interventions,  
12 modalities utilized, and progress response to  
13 interventions. So if CMS and Palmetto do not have  
14 any documentation requirements, why are you imposing  
15 the standard?

16 A Because CMS, there's still an overarching  
17 standard of care issue and I think this is where we  
18 might be talking apples and oranges a bit. The  
19 absence of CMS attempting to define psychotherapy  
20 guidelines does not -- okay. I'm just gonna say  
21 this is just my opinion. A common sense approach to  
22 that would not mean that there are no documentation  
23 requirements in that regard. And so, then the issue  
24 becomes remember my entire review is does the  
25 documentation, well, support necessary and

1 reasonable care. The absence of a defining variable  
2 for psychotherapy documentation by CMS standards  
3 does not mean that anything goes in my view. Now  
4 this is just my opinion, right. Being aware that  
5 CMS during the time in question had neither an LCD  
6 or a national coverage determination or definition  
7 doesn't mean that a provider can go in there and  
8 write anything or nothing which is, I'm getting  
9 ahead of myself, sometimes what happened here. They  
10 wrote anything or nothing and there are areas where  
11 the -- your coder, the coding report, we agreed a  
12 lot in my view. This is just my read of that  
13 report.

14 So I'm left to fall back on if CMS doesn't  
15 define what psychotherapy documentation is,  
16 there's -- somebody has to. And, of course, who's  
17 using these medical records really? Well, mental  
18 healthcare providers. So if I were to go bill a  
19 90833 and write that I was using leeches for PTSD,  
20 you could be making an argument that that's  
21 psychotherapy, maybe. But standard of care would  
22 suggest that that's just not -- that's nonsensical.  
23 And so, I'm forced to fall back as all providers are  
24 to what is necessary and reasonable, and what is  
25 that. Well, first of all, would another doctor be

1     able to come in if I get hit by a bus and pick up  
2     where I left off? Would that define that patient's  
3     care in a way that helps that patient? Or, for  
4     example, is the same psychotherapy progress note  
5     being dictated verbatim on seven occasions on seven  
6     different dates of service. That by definition  
7     suggests that that is not support for the standard  
8     of care.

9             Now back to your original question. The  
10     reality is is that, that these codes did not during  
11     the time in question define that. I would be of the  
12     opinion that then we just left with, well, is it  
13     necessary and reasonable. Does it serve its  
14     standard of care purposes? Does it serve its  
15     clinical purposes? Can a coder look at that and see  
16     what was done? Can a -- more importantly, can a  
17     physician look at it and see what was done? And  
18     that is where I think I filled in that blank because  
19     that's how I'm judged every day.

20     Q       So, but you didn't -- I hate to disagree  
21     with you.

22     A       That's okay.

23     Q       But you didn't review the records in that  
24     manner?

25             MR. FOWLER: Objection to form.

1 Q Okay, all right. On this one as well you  
2 note, you say no goal/response listed. Again, is  
3 the goal or response required by Medicare or  
4 Palmetto GBA?

5 A So --

6 MR. FOWLER: Objection to form.  
7 Objection to form.

8 A It is my under -- I'm sorry. I didn't hear  
9 what you said.

10 Q I asked if the goal --

11 MR. FOWLER: I was just objecting to  
12 form.

13 A Oh, okay. I'm sorry. I just went blank for  
14 a second. We're good. I -- with the understanding  
15 that that is not a described requirement in the  
16 code.

17 Q Okay. Let's answer that first.

18 A It is not. It is my understanding it is  
19 not.

20 Q Okay. It is not required by Palmetto GBA  
21 and CMS?

22 MR. FOWLER: Objection to form.

23 A Not specifically, but my interpretation of  
24 that --

25 Q It's not required by CMS, Palmetto GBA in a

1 NCD or LCD?

2 MR. FOWLER: Objection to form.

3 A That is true. And yet if you read the  
4 entirety of the purpose of the code not knowing what  
5 you're working towards or whether you're making  
6 progress negates my ability to determine whether  
7 that treatment was necessary or reasonable. And so,  
8 even if it's not stated there that you have to have  
9 it, it's -- another poor example is, like, if I have  
10 my appendix out, I want to know if I'm a doctor  
11 looking at that medical record whether I survived  
12 the surgery, right. And I know that's hyperbolic,  
13 but it's not that hyperbolic, right. You got to say  
14 what's going on. And in this case, we got the  
15 therapist, who I'm sure is a fine therapist,  
16 listening to this patient and that's important, but  
17 that's half of the equation.

18 Q Okay. So if a auditor, coding auditor, were  
19 looking at -- for -- at your critique of goal and  
20 response, they would say there's nothing in the OIG  
21 to support that?

22 MR. FOWLER: Objection to form.

23 A I'm assuming that that is what they would  
24 say and I have no reason to disagree with you --  
25 with that hypothetical. That demonstrates why it is

1 that the standard of care is not defined by that  
2 document, and it's clearly not. Well, in my view.  
3 And so, they're not requiring it, in my opinion,  
4 does not mean that if you're a Medicare patient, you  
5 don't get to have documentation that meets with this  
6 community standard of care.

7 Q So the OIG in its report went through and  
8 determined overpayments --

9 A Yes.

10 Q -- for certain services, right?

11 A They did, yes.

12 Q But they only determined overpayments, for  
13 example, with no goal and response listed to the  
14 extent one of the seven MACs had an LCD that  
15 required it. Did you know that?

16 A Not before today, no.

17 Q Okay. So in other words, the OIG itself did  
18 not require or identify an overpayment to the extent  
19 that a MAC did not require documentation -- the  
20 documentation requirement?

21 MR. FOWLER: Objection to form.

22 A I don't think I disagree with what you're  
23 saying.

24 Q Okay. Let's go to the -- back to the OIG  
25 report on page 39.

1 that in chief complaint, it would technically fill  
2 that requirement, right.

3 Q Okay. But you're ding a whole note  
4 because of that though.

5 A Well, I don't mean to ding -- yeah.

6 Q You are?

7 A Well, I guess I am, yes.

8 Q You are. And so, you can tell on the first  
9 page what the complaints are, can't you?

10 A Yes. I guess I don't have a way to split  
11 the baby there as it were.

12 Q Exactly. So do you think that's fair?

13 MR. FOWLER: Objection to form.

14 A I --

15 Q Well, do you seriously?

16 MR. FOWLER: Objection to form.

17 A It's -- it's -- it's -- I don't know that I  
18 can define fair. It's either -- it's either done  
19 correctly or it's not done correctly. All I can say  
20 is that I would get treated the same way I'm  
21 interpreting this.

22 Q Okay. Well, by whom? By a coder?

23 A By our -- I don't know that -- by our  
24 internal auditors which I think are coders.

25 Q Okay. So we're not talking about that right

1 now. We're talking about, you know, we're in a  
2 coding audit here. And you can tell on the first  
3 page --

4 MR. FOWLER: Objection to form.

5 A Well, our auditors are coders.

6 Q You can tell on the first page --

7 A Yeah.

8 Q -- that this patient -- what the complaints  
9 are.

10 A So the --

11 Q You're saying the whole note fails because  
12 it's not under chief complaint?

13 MR. FOWLER: Objection to form.

14 A Yeah.

15 Q Okay.

16 A I mean, because it's not in -- it's not  
17 where it needs to be. There's -- there's a reason  
18 --

19 Q That's fine. You're saying that's not --

20 A Okay.

21 Q Okay. So then, I've got History of Present  
22 Illness on the next page. Suicidal, talked about  
23 the gun, the duration of timing?

24 A Wait. Which page are we talking about?

25 Q So the first page is the History of Present

1     Illness. The second page, and I'll go a little  
2     slower, 537217?

3           A     No. It's 5316, isn't it?

4           Q     Oh, sorry. I missed a page. You're right,  
5     yeah. The second page, 16 doesn't have anything on  
6     it, but then if we go to -- I missed a page.  
7     537217, you got a discussion of suicidal, denies. A  
8     gun in the house, no. Duration and timing, chronic.  
9     Severity severe?

10          A     Uh-huh.

11          Q     The next page 537218, modified factors are  
12     present, associated signs and symptoms, anxiety. No  
13     SI, suicidal ideation; is that right?

14          A     You're right, right.

15          Q     Okay. Side effects, none. They talked  
16     about the smoking status, never a smoker. Talked  
17     through the substance abuse and dependence. Talked  
18     about appearance and functioning?

19          A     Uh-huh.

20          Q     Talked about compliant or not with  
21     medications. Again a review of the prior PFSH and  
22     no change in that. And if you look on page 53729,  
23     that prior PFSH was in fact --

24          A     Seven --

25          Q     537219?

1 A Oh, 219, okay.

2 Q The prior PFSH was re-examined?

3 A Right.

4 Q You see that?

5 A Uh-huh.

6 Q Okay. Then we go over -- we go over to  
7 mental status exam and that, well, that's just on  
8 page 53722?

9 A Uh-huh.

10 Q Appearance, well groomed. Go to the next  
11 page. Mood, anxious. Affect, congruent with mood.  
12 Denies suicide. Attention span and concentration is  
13 good. The next page, judgment and insight are  
14 discussed. And then, on page 537244, there's also a  
15 nice assessment. Do you see that?

16 A I do, yes.

17 Q Okay. And, in fact, that assessment  
18 continues in end note 1. So it's not just what's  
19 documented here.

20 A Oh, no, no. I got you.

21 Q The end note 1 is 537299. All righty.

22 A Right.

23 Q Okay. And then, on page 537255, there's a  
24 plan. Patient understands and agrees with treatment  
25 goals. Patient understands they may call at any

1     that it's couple-fold. One, let's start with the  
2     baseline is if you are actively engaged in  
3     psychotherapy, can you reasonably assert that having  
4     a second psychotherapist is a necessary and  
5     reasonable service or absent more, would it be a  
6     duplicative service? But on top of that from a  
7     clinician standpoint, my concern is that, well, too  
8     many chefs spoils the mix. So I'll admit, I don't  
9     know how familiar this therapist is with the  
10    therapist -- the other therapist, C Peoples, but it  
11    is more -- there is more than one way to skin a cat.  
12    And if you have two therapists messing around in the  
13    same psychopathology, you can do more harm than  
14    good. It can be confusing to the patient. You can  
15    wind up giving different interpretations or  
16    psychotherapeutic interventions that conflict with  
17    each other when neither of those interventions is  
18    wrong. But when a patient gets both at the same  
19    time, it can be very confusing.

20       Q     Okay. So it's not -- not something that's  
21    in the CPT coding books, correct?

22       A     Well, I mean the book does say it needs to  
23    be necessary and reasonable and it's not necessary  
24    and reasonable to have two therapists.

25       Q     How can you tell that?

1 A Because I'm a psychiatrist. I mean --

2 Q I mean, how could you tell -- wasn't the  
3 provider the one who's able to tell at that time  
4 whether the psych -- the short amount of 90833 they  
5 provided the patient wouldn't also benefit from  
6 therapy from C Peoples?

7 MR. FOWLER: Objection to form.

8 A I think the patient was in therapy with C  
9 Peoples and he should have left that alone. That's  
10 the clinical standard.

11 Q That's your opinion though. Didn't --  
12 couldn't this provider have had a different opinion  
13 on that?

14 MR. FOWLER: Objection to form.

15 A He would be standing apart from -- yes. He  
16 could have a different opinion.

17 Q Okay. And then, and so what's your source?  
18 Besides your opinion, what is your source? Can you  
19 point me to a CPT code book? Can you --

20 A No, not a CPT --

21 Q -- point me to a LCD?

22 A -- code book.

23 Q How about an LCD?

24 A No.

25 Q NCD?

1           A       No. That says you can't have more than one  
2 therapist? I don't know how they wouldn't interpret  
3 that as duplication of service, but that's fine. I  
4 mean --

5           Q       But there's no NCD that says you can't have  
6 a patient -- in fact, Medicare will pay for multiple  
7 therapists, won't they?

8                   MR. FOWLER: Objection to form.

9           A       I'm not a coding person, so I don't know  
10 what they'll pay for. But that would not -- but as  
11 a clinician, I'll tell you it's not necessarily  
12 reasonable or recommended.

13          Q       Okay. But you don't know in this case  
14 what -- do you know who C Peoples is?

15          A       Yeah. That's a name -- I don't know C  
16 Peoples but it's somebody, you know, there's not  
17 that many of us around.

18          Q       Okay. But do you know what kind of therapy  
19 C Peoples was doing?

20          A       No. And I don't know that this person does  
21 either. It doesn't say.

22          Q       But again, you don't know so how can you say  
23 it wasn't medically necessary when you don't even  
24 know who C Peoples is or what therapy they were  
25 practicing?

1 A Oh, yeah. The note itself is good.

2 Something is wrong with the --

3 Q The note itself is good?

4 A Yeah.

5 Q It meets the CPT code requirements for 2020.

6 Would you agree with that?

7 MR. FOWLER: Objection to form.

8 A Uh --

9 Q That we discussed about the three factors?

10 A Yes.

11 Q Okay. And then, you remember that when you  
12 were looking at documenting E/M, you don't have to  
13 record time if it's -- in fact, the CPT code book  
14 says you shouldn't if it's related to the time based  
15 code like 90833?

16 MR. FOWLER: Objection to form.

17 A Is the argument that you can make errors in  
18 the record and be forgiven for that?

19 Q Did I -- did I ask you that?

20 A That is what you're asking.

21 Q That's not what I'm asking. I'm asking the  
22 E/M CPT code book says that time is not a  
23 requirement and shouldn't be recorded for these E/M  
24 codes.

25 A But I would suggest --

1 MR. FOWLER: Objection to form.

2 A -- that if you write a record that suggests  
3 --

4 Q So can you answer my question though?

5 A Yes. That -- what you're saying is correct.

6 Q Okay, thank you.

7 A I would add to that saying that, but it -- I  
8 mean I'm trying not to say that it doesn't make  
9 sense --

10 Q Okay. Well, let's --

11 A -- to not question a note that says you did  
12 all that work in zero minutes.

13 Q So they did all this work. Does it make  
14 sense it wasn't done?

15 A Then it makes me wonder what was done.

16 Q Okay. Let's look at it, okay. On page --

17 A No. I'm not -- I'm not talking about the  
18 E/M. I know it was done. It's documented.

19 Q Okay. So that's all we're talking about  
20 right now is the E/M.

21 A Right.

22 Q You know it was done as documented?

23 A Well, it can't be done as documented. It  
24 can't be done as documented because it's documented  
25 it was done in zero minutes.

1 Q It does not say that.

2 A It says that exactly.

3 Q It says that in another part of the record.

4 A Well, okay. I mean if I break them apart.  
5 Each note stands on its own.

6 Q Are you saying that this -- it's just --

7 A I'm not saying that it was made up.

8 Q All right.

9 A That's not what I'm saying.

10 Q Okay. So let's say that.

11 A All right.

12 Q So are you not saying that there isn't  
13 sufficient documentation --

14 MR. FOWLER: Objection to form.

15 Q -- to support the CPT code as described in  
16 the CPT code book?

17 A That -- right. If the note -- if the times  
18 were right, the documentation for the E/M code is  
19 sufficient. The note is fatally flawed in that  
20 regard. It needs to say what really happened.

21 Q Okay. Does -- it said what really happened.

22 A So they did all that in zero minutes.

23 Q No. You're making -- you're building an  
24 assumption that's not true here.

25 MR. FOWLER: Objection to form.

1 time today. I appreciate it.

2 THE WITNESS: Thank you.

3 MR. FOWLER: I have just a few.

4 EXAMINATION

5 BY MR. FOWLER:

6 Q There was a lot of discussion about  
7 reasonable and necessary. Can you explain what you  
8 mean by reasonable and necessary?

9 A Right. So -- so it is -- it's undeniably a  
10 clinical term. And what it describes is a course of  
11 treatment reasonably applicable to a source of  
12 pathology or a condition, and is it necessary for  
13 management of that condition. And so, it really  
14 speaks to we don't want to provide treatment that is  
15 inappropriate for a condition, known to be  
16 ineffective for a condition, or not reasonable in  
17 terms of its approach to managing the condition  
18 efficiently.

19 Q Okay. Are you familiar with the old forms  
20 called 1500 paper forms?

21 A Oh, yes.

22 Q Was -- was reasonable and necessary one of  
23 the certifications that had to be made on that old  
24 1500 form?

25 A It was like signing an affidavit essentially

1 swearing that you believe what you are doing is  
2 reasonable and necessary for that condition.

3 Q Do you know if the electronic forms include  
4 any similar requirement of these claims submitted to  
5 be reasonable and necessary?

6 A Pretty sure they do.

7 Q Okay. Is that also part of the provider  
8 agreement that every provider has to sign with  
9 Medicare?

10 MS. HARRIS: Object to the form.

11 A Oh, so it is on mine anyway, yes.

12 MS. HARRIS: Object to the form.

13 A Sorry.

14 Q So reasonable and necessary is part of the  
15 requirement in your provider agreement with  
16 Medicare?

17 MS. HARRIS: Object to the form.

18 A That's true.

19 Q Do you understand that's also a requirement  
20 of the statute?

21 MS. HARRIS: Object to the form.

22 A Yes.

23 Q Okay. Now there was a lot discussion about  
24 LCDs and lack of an LCD. Does a lack of an LCD  
25 change what's reasonable and necessary for a claim

1 submitted for psychotherapy?

2 MS. HARRIS: Object to the form.

3 A Not in my opinion, it does not.

4 Q And there was also a lot of discussion about  
5 NCDs, the lack of NCDs. Does that change what is  
6 reasonable and necessary in your view?

7 A It does not in my view.

8 Q There was a discussion about the HHS OIG  
9 2023 report which you had lots of questions about.  
10 Does anything in that report or any of the testimony  
11 you've given change your view about what is  
12 reasonable and necessary for these claims?

13 MS. HARRIS: Object to the form.

14 A It does not.

15 Q Okay. Did that report go into what was  
16 reasonable and necessary?

17 MS. HARRIS: Object to the form.

18 Q As opposed to what the specific MACs were  
19 requiring?

20 MS. HARRIS: Object to the form.

21 A Having not read the entire report, I'm not  
22 sure how to say that, how to answer that.

23 Q Okay. So you don't know if they focused on  
24 reasonable and necessary versus what the additional  
25 requirements were by the MACs?

1 MS. HARRIS: Object to the form.

2 A Well, I would -- no, I don't, but I would --  
3 well, it would be hoped that reason -- that they  
4 would -- that they would maintain a focus at the end  
5 of the day on providing treatment that is necessary  
6 and reasonable and paying for treatment that's  
7 necessary and reasonable.

8 MS. HARRIS: Object to the form.

9 Q And we heard you, I think, say this many  
10 different times, but is reasonable and necessary a  
11 requirement for billing purposes only or is it  
12 required also for standard of care purposes?

13 A It is standard --

14 MS. HARRIS: Object to the form.

15 A It is standard of care as well.

16 Q Okay, all right. So why is it important in  
17 both areas?

18 MS. HARRIS: Object to the form.

19 A So in the first form for billing purposes,  
20 of course, if you're providing medical services, you  
21 want to document to the person paying the bill what  
22 you are doing. And you want to document in such a  
23 way that they know, the payor knows that you are  
24 deeming this necessary and desirable but more  
25 important, necessary and reasonable, but more

1 importantly documenting it that they -- so that the  
2 trier -- that the person looking at that submission  
3 can say, yeah. This is right.

4 From a standard of care issue why it's  
5 important is because it violates our oath as  
6 physicians to knowingly provide care that is  
7 reasonably expected not to work or known to be  
8 ineffective or known to be not appropriate or not  
9 needed for a condition.

10 Q Okay. And not need could be because there's  
11 duplicate -- there's a provider somewhere else?

12 A Duplicate -- duplicate services would be an  
13 example of that.

14 Q Now you reviewed the report of the billing  
15 expert, Ms. Nogowski (phonetic). And you were asked  
16 questions just about where you disagreed with her  
17 and, I think, there were 18 or so of those. There  
18 were no questions about where she agreed with you.  
19 But the reason for your denial of a lot of the  
20 90833s that she agreed with are in your report,  
21 correct?

22 A That is correct.

23 Q I don't want to go through all that for the  
24 sake time, but she agreed with many of your 90833  
25 decision. She disagreed, I believe, with all of

1 your E/M decisions?

2 A Right. It's sort of --

3 MS. HARRIS: Object to the form.

4 A So as I recall that what you just said is  
5 true. I think the notes that I found acceptable,  
6 she found all of them acceptable.

7 Q Right.

8 A And then, there was a -- I would -- I would  
9 say describe it as a significant area of agreement  
10 between us.

11 Q Okay. And in your questioning from Mindpath  
12 counsel, you were asked typically about the part  
13 that you disagreed with. So if there was agreement  
14 on 90833 but a disagreement on the E/M, they only  
15 asked you about one. But your report stands as it  
16 does regarding your denials in some cases for both  
17 the E/M and the 90833?

18 A Oh, that is still true, yes.

19 Q Okay. So I won't go back into that just for  
20 the sake of time. And it's your view, I believe you  
21 stated that the 90833 notes should stand alone as in  
22 the 90833 part of the notes should explain the  
23 medical necessity of the claim, correct?

24 A That is correct.

25 MS. HARRIS: Object to the form.

1 A Because it's a distinct treatment.

2 Q Right. And the requirement to document is  
3 separate and distinct between the 90833 and the E/M?

4 A That is my understanding as well. I mean  
5 yes, that's correct.

6 Q Okay. There were questions about some clone  
7 notes for Patient CM, 12/7 of 2020, Exhibit 348?

8 A Right.

9 MS. HARRIS: Object to the form.

10 Q And there were other notes, progress notes  
11 that you looked at that you said were adjacent to,  
12 just before and just after, that date that you  
13 thought were cloned or identical?

14 A That's correct.

15 Q And obviously, counsel didn't want you to go  
16 into that but that was something that you found when  
17 you looked back over this based on the review from  
18 Ms. Nogowski, correct?

19 MS. HARRIS: Object to the form.

20 A That is correct. I was just prepping  
21 yesterday and I looked at that. And I was like, you  
22 know, and I got curious. Maybe I shouldn't have  
23 done that, but I started looking a little more.

24 Q But that supports your overall opinion  
25 regarding the denial of claims for Patient CM,

1 12/7/2020?

2 MS. HARRIS: Object to the form.

3 A Well, it does to -- yes.

4 Q Okay. You also talked about having 90833s  
5 inextricably intertwined with the E/M. Why is it  
6 inextricably intertwined?

7 A So, because what we're doing here is it's --  
8 they're two distinct modes of treatment, but it's  
9 one person. And I know it's really, really hard  
10 sometimes to sort of ferret that all out. But at  
11 the end of the day, the provision of therapy is a  
12 distinct service as opposed to managing medicines or  
13 sort of the things that happen in E/M evaluation and  
14 management services. It's still that same patient.  
15 And they need to tie -- they need to be consistent  
16 with each other. So an example being if -- not to  
17 get back into this, but if one note seems to me to  
18 clinically describe someone who either won't engage  
19 in treatment or can't, then it seems perhaps not  
20 necessary or reasonable to then engage -- attempt to  
21 engage them in therapy.

22 Q Can a 90833 be billed on its own without an  
23 underlying E/M code?

24 A No.

25 Q Okay. By definition it's an add-on?

1 A It's an add-on code.

2 MR. FOWLER: Unless you have further  
3 questions, that's it.

4 EXAMINATION

5 BY MS. HARRIS:

6 Q I've got one further question and that's  
7 let's go back to the OIG report.

8 A That is your favorite. Let's see here.

9 Q It is my favorite.

10 A Hang on. I'll find it. It's thick, right?

11 Q It is.

12 MR. FOWLER: It's number 301.

13 A They're all out of order now. I'll get it.  
14 It'll be quick. I swear I didn't steal it.

15 MR. FOWLER: This is mine, but he's  
16 welcome to use it.

17 Q Just want to look at one page, page 39.

18 A Okay.

19 MS. HARRIS: Unless you have notes that  
20 say please say -- no. I'm playing with you.

21 MR. FOWLER: I just tabbed it.

22 BY MS. HARRIS:

23 Q We had to use my yellow highlighting so,  
24 anyway. On page 39, you remember we talked about  
25 the appendix where the OIG lists psychotherapy --

1 STATE OF NORTH CAROLINA

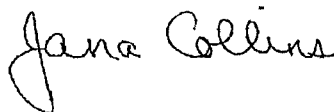
2 COUNTY OF FORSYTH

3 REPORTER'S CERTIFICATE

4 I, Jana Collins, a Notary Public in and for  
5 the State of North Carolina, do hereby certify that  
6 there came before me on Tuesday, the 11th of March,  
7 2025, the person hereinbefore named, who was by me  
8 duly sworn to testify to the truth and nothing but  
9 the truth of his knowledge concerning the matters in  
10 controversy in this cause; that the witness was  
11 thereupon examined under oath, the examination  
12 reduced to typewriting under my direction, and the  
13 deposition is a true record of the testimony given  
14 by the witness.

15 I further certify that I am neither attorney  
16 or counsel for, nor related to or employed by, any  
17 attorney or counsel employed by the parties hereto  
18 or financially interested in the action.

19 IN WITNESS WHEREOF, I have hereto set my  
20 hand, this the 14th of March, 2025.

21  
22   
23

24 Jana Collins, Notary Public

25 Notary Number: 200733100028